EVANS MEDICAL GROUP

PEDIATRIC HISTORY

Patient's Full Name: _____ Date of Birth: _____

ALLERGIES:

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

	ALLERGY	REACTION
1.		
2.		
3.		
4.		

PAST MEDICAL HISTORY

[ ] Acid Reflux Disease (or GERD)
[ ] Allergies
[ ] Attention Deficit Disorder (ADD or ADHD)
[ ] Asthma
[ ] Birth Defect
[ ] Bleeding Disorder
[ ] Blood Clots (or DVT)
[ ] Cancer
[ ] Developmental/Learning Problems
[ ] Diabetes
[ ] Genetic Disorder
[ ] High Blood Pressure
[ ] Psychiatric/Behavioral Problems
[ ] Speech Disorder
[ ] Other_____

MEDICATIONS:

List all medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

	DRUG NAME	STRENGTH	FREQUENCY TAKEN (ie, once a day)
1.			
2.			
3.			
4.			

IMMUNIZATION HISTORY:

Vaccines are up-to-date as far as I know [ ]Yes [ ]No

List the previous physician/facility where vaccines were given so that we may try to obtain those records:

_____

What city and state is that in? _____

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FAMILY HEALTH HISTORY:

(Indicate with an "X" which family member has a history of which illness.)

	Mom	Dad	Brother(s)	Sister(s)
Asthma				
Diabetes				
Sickle Cell				
Bleeding Problems				
Seizures				
Heart Disease				
High Blood Pressure				
Psychiatric Disease				
Cancer (type)				

Other family health history that you think your physician should consider important information concerning your health (such as children with heart problems or genetic conditions):

_____

SOCIAL HISTORY:

Nickname: _____
Mother's name: _____
Father's name: _____
Step-Mothers name: _____
Step-Fathers name:_____
Church/group Attended:_____
Lives at home with:
[ ] Father [ ] Mother [ ] Step-Mother [ ] Step-Father [ ] Siblings [ ] Extended Family
School Attended:_____ Grade:_____

PAST SURGICAL HISTORY:

SURGERY REASON YEAR HOSPITAL SURGEON

1._____
2._____

Other hospitalizations?_____

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PATIENT'S PRENATAL/BIRTH HISTORY:

Patient's birth weight: _____
How many weeks along was the pregnancy at the time of birth? _____
[ ] C-Section [ ] Vaginal Delivery Hospital of Delivery: _____
Complications with Delivery? _____

YOUR CARE TEAM:

List doctors you see regularly and their specialty:

Doctor_____Specialty_____
Doctor_____Specialty_____

Thank you for completing this form